EDMUND G. BROWN JR., Attorney General
of the State of California
ALFREDO TERRAZAS
Senior Assistant Attorney General
ARTHUR D. TAGGART, State Bar No. 83047
Supervising Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 327-6819
Facsimile: (916) 324-5567

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: GRANT WAYNE COOPER 4240 North 4th Avenue Phoenix, AZ 85013 Registered Nurse License No. 531079 Respondent.	Case No. 2008-198 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 25, 1997, the Board issued Registered Nurse License Number 531079 to Grant Wayne Cooper ("Respondent"). Respondent's registered nurse license was in full force and effect all times relevant to the charges brought herein and will expire on May 31, 2008, unless renewed.

///

///

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action . . .

Cost Recovery

6. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

///

///

///

///

///

CAUSE FOR DISCIPLINE

(Disciplinary Actions by the Arizona State Board of Nursing)

7. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Arizona State Board of Nursing (hereinafter "Arizona Board"), as follows:

a. On or about September 4, 2002, pursuant to Consent Agreement and Order No. 9912062 in the disciplinary proceeding titled *In the Matter of Professional Nurse License No. RN094171 and Advanced Practice Certificate No. AP851 Issued to: Grant Cooper,* the Arizona Board ordered that a Decree of Censure be entered against Respondent's Professional License No. RN094171 and Advanced Practice Certificate No. AP851. Pursuant to the consent agreement, Respondent admitted as follows: On or about December 8, 1999, Respondent was working for Health Temp as a registered nurse in the critical care unit at John C. Lincoln Hospital, Phoenix. Patient A.T.'s physician wrote an order to clamp A.T.'s chest tube and discontinue suction on the "chest bottles" (water seal device), a standard order to determine if a patient is physiologically ready to have a chest tube removed. Respondent clamped the chest tube of postoperative patient A.T., but then cut the chest tube free from the water seal device. Respondent believed that the physician had verbally ordered him to cut the tubing prior to the tube being removed, but Respondent did not document the verbal order, did not attempt to clarify the order with the physician, and did not document in the medical record that the chest tube was cut. A true and correct copy of Consent Agreement and Order No. 9912062 is attached hereto as Exhibit "A" and incorporated herein by reference.

b. On or about March 28, 2007, pursuant to Findings of Public Emergency and Order of Summary Suspension No. 0601022, in the disciplinary proceeding titled *In the Matter of Professional Nursing License No. RN094171 and Advanced Practice Certificate No. AP0851 Issued to: Grant Wayne Cooper*, the Arizona Board summarily suspended Respondent's professional nurse license and advanced practice certificate. A true and correct copy of Findings of Public Emergency and Order of Summary Suspension No. 0601022 is attached hereto as Exhibit "B" and incorporated herein by reference.

c. On or about September 19, 2007, pursuant to Findings of Fact, Conclusions of Law and Modified Order No. 07A-0601022-NUR, in the disciplinary proceeding referenced in subparagraph (b) above, the Arizona Board lifted the summary suspension of Respondent's professional nurse license and placed Respondent's license on probation for 18 months with terms and conditions. The Arizona Board also suspended Respondent's advanced practice certificate for 6 months with terms and conditions. A true and correct copy of Findings of Fact, Conclusions of Law and Modified Order No. 07A-0601022-NUR is attached hereto as Exhibit "C" and incorporated herein by reference. The Arizona Board based its disciplinary order on the following findings:

1. Respondent administered excessive medication to patient R.S. at Phoenix Memorial Hospital ("PMH") on January 7, 2006.

2. Respondent failed to confirm the physician's orders for medication for patient E.W. at PMH on January 13, 14, and 16, 2006, and thus administered medication to E.W. over the course of three days without a valid order.

3. Respondent prescribed Valium to his wife.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 531079, issued to Grant Wayne Cooper;

2. Ordering Grant Wayne Cooper to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

///

///

///

///

///

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/20/07.

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

03579-110-SA2007101628
phd; 11/27/2007

EXHIBIT A

CONSENT AGREEMENT AND ORDER NO. 9912062

Janet Napolitano
Governor

Joey Ridenour
Executive Director

Arizona State Board of Nursing
4747 North 7th Street, Suite 200
Phoenix AZ 85014-3653
Phone (602) 889-5150 Fax (602) 889-5155
E-Mail: arizona@azbn.org
Home Page: http://www.azbn.org

AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF ARIZONA

COUNTY OF MARICOPA

I, Joey Ridenour, Executive Director for the Arizona State Board of Nursing, County of Maricopa, State of Arizona, do hereby certify that I am the officer having the legal custody for the records hereto attached in the office of the Arizona State Board of Nursing, County of Maricopa, State of Arizona, a public office of said State. The attached copies are true copies of the records on **GRANT WAYNE COOPER**. Personnel of the Arizona State Board of Nursing prepared the records during the ordinary course of business.

Witness my hand and the seal of the Arizona State Board of Nursing at 4747 North 7th Street, Suite 200, Phoenix, Arizona 85014 on April 20, 2007.

SEAL

Joey Ridenour RN MN

Joey Ridenour, R.N., M.N.
Executive Director

BEFORE THE ARIZONA STATE BOARD OF NURSING

IN THE MATTER OF PROFESSIONAL NURSE LICENSE NO. RN094171 AND ADVANCED PRACTICE CERTIFICATE NO. AP851 ISSUED TO: GRANT COOPER RESPONDENT	)	**DECREE OF CENSURE** **CONSENT AGREEMENT AND ORDER NO: 9912062**

A complaint charging Grant Cooper ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements and the responsibilities of the Board, and pursuant to A.R.S. § 41-1092.07 (F)(5), the undersigned parties enter into this Consent Agreement as a final disposition of this matter:

Based on the evidence before it, the Board makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. Respondent holds Professional Nurse License No. RN094171 and Advanced Practice Certificate No. AP851 in the State of Arizona.

2. On or about August, 1996, Respondent began employment as an RN with Health Temp, a nursing registry, in Mesa, Arizona.

3. On or about December 8, 1999, Respondent was working for Health Temp as an RN in the critical care unit at John C. Lincoln Hospital, Phoenix. Patient A.T.'s physician wrote an order to clamp A.T.'s chest tube and discontinue suction on the "chest bottles" (water seal device), a standard order to determine if a patient is physiologically ready to have a chest tube removed. Respondent clamped the chest tube of postoperative patient A.T. but then cut the chest tube free from the water seal device.

4. Respondent stated he believed the physician had verbally ordered him to cut the tubing prior to the tube being removed, but that he did not document the verbal order and that it may have been a misunderstanding. Respondent did not attempt to clarify the order with the physician and did not document in the medical record that the chest tube was cut.

5. On or about December 9, 1999, A.T.'s chest tube was removed without sequelae.

CONCLUSIONS OF LAW

1. Pursuant to A.R.S. §§ 32-1606, 32-1663 and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

2. The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. § 32-1663 (D); A.R.S. § 32-1601 (14) (d) and (j); and A.A.C. R4-19-403 (5,) (6), and (25).

3. The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to AR.S. § 32-1664 (N) to revoke, suspend or take other disciplinary action against the license of Respondent to practice as a professional nurse in the State of Arizona.

4. Respondent admits the Board's Findings of Fact and Conclusions of Law.

5. In lieu of a formal hearing on these issues, Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal or judicial review relating to this Consent Agreement and Order.

6. Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

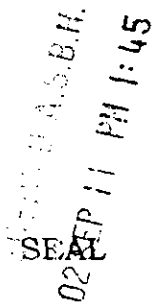
7. Respondent understands that those admissions are conclusive evidence of a prior violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

8. Respondent understands the right to consult legal counsel prior to entering into this Consent Agreement and such consultation has been either obtained or is waived.

//

//

9. Respondent understands that this Consent Agreement is effective upon its acceptance by the Board and the Respondent.



SEAL

Respondent

Dated: 9/4/2

ARIZONA STATE BOARD OF NURSING

Joey Ridenour, R.N., M.N.
Executive Director

Dated: July 19, 2002

GRADY/RN094171COOPER

//

//

//

//

//

//

//

//

//

//

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, the parties agree to the provision and penalties imposed as follows:

1. Respondent's consent to the terms and conditions of this Order and waiver of public hearing are accepted.

2. It is ordered that a DECREE OF CENSURE be entered against license no. RN094171 and advanced practice certificate no. AP851, held by Respondent.

ARIZONA STATE BOARD OF NURSING

Joey Ridenour, R.N., M.N.
Executive Director

JR/KG:sn

COPY mailed this 3rd day of September, 2002, by First Class Mail to:

Grant Wayne Cooper
6336 W. Honeysuckle Dr.
Glendale, AZ 85310

By: _____
Legal Secretary

EXHIBIT B

FINDINGS OF PUBLIC EMERGENCY AND ORDER OF SUMMARY SUSPENSION NO. 0601022

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street, Suite 200
Phoenix, Arizona 85014-3653
602-889-5150

IN THE MATTER OF PROFESSIONAL NURSING LICENSE NO. RN094171 and ADVANCED PRACTICE CERTIFICATE NO. AP0851 ISSUED TO: GRANT WAYNE COOPER, RESPONDENT.	**FINDINGS OF PUBLIC EMERGENCY AND ORDER OF SUMMARY SUSPENSION No. 0601022**

This matter came before the Arizona State Board of Nursing ("Board") on March 28, 2007, at 1:00 p.m., at 4747 North 7th Street, Second Floor Board Room, Phoenix, Arizona 85014, at which time and place the Board considered the Summary Suspension of Respondent's professional nurse license no. RN094171 and advanced practice certificate no. AP0851, to practice as a nurse and advanced practice nurse in the State of Arizona.

FINDINGS OF FACT

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§32-1606, 32-1646, 32-1663, 32-1664, 41-1064 (C), 41-1092.11(B), and 41-1092.07(F)(5). The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§32-1601 to -1667.

2. Respondent holds Board issued professional nurse license no. RN094171 and Advanced Practice Certificate no. AP0851.

3. From on or about December 2002, until the present time, Respondent has been employed by Alacrity Staffing in Phoenix, Arizona and was working as a professional registry staff nurse, primarily assigned to critical care units, emergency units and/or telemetry units.

COMPLAINT #1

4. On or about January 25, 2006, the Board received a complaint against Respondent alleging that he committed unprofessional conduct by frequently signing out controlled substances and over-medicating and over-sedating his assigned patients in the Cardiovascular Intensive Care Unit (CVICU) at Phoenix Memorial Hospital (PMH), while employed as registry nurse through Alacrity Staffing. On January 24, 2006 PMH's Director of Critical Care, Robert Garner, RN, BSN notified Respondent's employer (Alacrity Staffing) that he was a "Do Not Return" to PMH based upon these allegations.

THE INVESTIGATION

5. On or about February 16, 2006, Board staff interviewed PMH's Director of Clinical Practice, Marie Gagnon. According to Ms. Gagnon, three physicians brought concerns that Respondent was administering high doses of narcotics and sedative medications (Propofol) and expressed concerns that his patients could not be weaned or removed from ventilators. Ms. Gagnon asserted when she reviewed selected patient records assigned to Respondent and discovered that he administered Morphine Sulfate intravenously (IVP) on January 13, 14, and 16, 2006 to patient E. W. without a valid physician's order.

6. On or about March 15, 2006, Ms. Gagnon contacted Board staff and reported that Respondent had telephoned a Respiratory Therapist (RT) four or five times expressing anger about

the complaint filed with the Board. The Director stated that the ICU staff including RTs stated they were fearful of Respondent and possible retaliation from him.

7. On or about May 17, 2006, Board staff interviewed PMH's Director of Risk Management, Debrah Hartman. According Ms. Hartman, two physicians, Dr. Khanna and Dr. Van Poppel contacted her and expressed concern that Respondent might be diverting narcotics and asserted that when Respondent was assigned to their patients, he would frequently call them in order to change medications and have the other doctor "cover" the order. Ms. Hartman was also aware of the fact that after a Board complaint was filed, respiratory therapists told her that Respondent called and threatened them, causing them and other ICU staff to be fearful of their safety.

8. On or about March 20, 2007, Board staff interviewed PMH's Critical Care Coordinator and Interim Director of Critical Care Services, Julie Saltzman. Ms. Saltzman expressed concern that Respondent failed to contact physicians to discuss alternative pain management therapy for patients E.W., R.S. and M.C., after documenting he administered the highest dose of ordered narcotic analgesics every two hours without a decrease or resolution of the patients' pain threshold.

9. On or about March 21, 2007, Board staff interviewed Robert Garner, Interim Chief Nursing Officer and former Director of Critical Care Services at PMH. According to Mr. Garner, he counseled Respondent after hearing complaints from PMH physicians who believed that Respondent overused high doses of ordered narcotic analgesics and intravenous sedatives, specifically Propofol, when other nurses caring for patients E.W., R.S., and M.C. did not.

10. On or about March 21, 2007, Mr. Garner further asserted that he counseled Respondent for failing to follow PMH policy on "Medication Reconciliation", specifically the section which dealt with a "Change in the Level of Care" after reviewing the medical record of patient E.W.

Mr. Garner stated that Respondent was familiar with this policy in which previous physician orders were discontinued when a patient transferred from a different level of care and previous orders may not be utilized unless re-written by the physician. Mr. Garner said when E.W. transferred from the cardiac catherization laboratory to the CVICU, all previous orders were discontinued. Mr. Garner stated that it was Respondent's responsibility to perform a chart check of E.W.'s orders and contact the physician if E.W. required pain medication.

PATIENT E.W. DOCUMENT REVIEW

11. On or about January 13, 2006, January 14, 2006, and January 16, 2006, Respondent was assigned to provide care to E.W. from 7 a.m. to 7 p.m. on January 13, 2006, at PMH, according to medical record number M000530874.

12. Board staff reviewed E.W.'s medical record which revealed the following physician order written on January 11, 2006, "Morphine 4 mg IVP every 3 hours prn (severe pain), when E.W. was a patient on the telemetry floor.

13. On or about January 12, 2006, E.W. was transferred to the CVICU after undergoing a cardiac catherization. E.W.'s medical record revealed that his physician did not prescribe any narcotic analgesic after this procedure.

14. On or about January 13, 2006, Respondent documented on the medication administration record (MAR) and without current physician orders in place, that he administered Morphine Sulfate (MSO4) 4 mg intravenous push (IVP) to E.W. at 8 a.m., 11 a.m., and 2 p.m. E.W. did not receive MSO4 from any other nurse assigned to care for him on January 13, 2006.

15. On or about January 14, 2006, Respondent documented on the MAR and without current physician orders in place, that he administered MSO4 4mg IVP to E.W. at 8 a.m., 11 a.m., 2

p.m. and 5 p.m. E.W. did not receive MSO4 from any other nurse assigned to care for him on January 14, 2006.

16. On or about January 16, 2006, Respondent documented on the MAR and without current physician orders in place, that he administered MSO4 4mg IVP to E.W. at 7:30 a.m., 10:45 a.m. and 1:50 p.m. E.W. did not receive MSO4 from any other nurse assigned to care for him on January 16, 2006.

RESPONDENT'S INTERVIEW

17. On or about March 20, 2007, during an interview with Board staff, Respondent acknowledged he was aware of PMH's "Change in Level of Care" policy but stated he believed at the time he was caring for E.W., that he could "go back 12 hours" and use a previous order written for MSO4. Respondent stated that E.W.'s MAR had a computer generated order from January 11, 2006 for MSO4 4 mg IVP every 3 hours.

18. On or about March 20, 2007, after Respondent reviewed E.W.'s physician orders and MARs, he acknowledged that the MSO4 order written on January 11, 2006 was discontinued after E.W. transferred to the CVICU. Respondent stated he was responsible for insuring that the medications he administered had a current and valid order.

PATIENT R.S. DOCUMENT REVIEW

19. On or about January 7, 2006, Respondent was assigned from 7 a.m. to 7 p.m. to CVICU patient R.S., after patient had post-operative coronary artery bypass (CABG) procedure, medical record number M000530678.

20. On January 7, 2006, post-operative orders for R.S. written by his physician reflected the following:

a) "While pt. intubated use the following for pain control: MSO4 2mg IVP every 1 hour prn for mild pain (1 - 3 on pain scale); MSO4 3mg IVP every 1 hour prn for moderate pain (4 -7 on pain scale); and MSO4 4 mg IVP every 1 hour prn for severe pain (8 – 10 on pain scale);" and

b) "When tolerating PO use the following for pain control: Percocet (5/325) 1 tablet PO every 4 hours for mild pain; Percocet 1 tablet PO every 4 hours for moderate pain; and MSO4 3mg IVP every 2 hours for severe pain."

21. On January 7, 2006, Respondent documented on R.S.'s MAR that he administered MSO4 4mg IVP at 7:30 a.m., 8:30 a.m., 9:30 a.m., 10:30 a.m., 11:30 a.m., 12:30 a.m., 1:30 p.m., 2:30 p.m., 3:30 p.m., 4:30 p.m., 5:30 p.m., and 6:30 p.m.

22. On January 7, 2006, Respondent documented on R.S.'s critical care flowsheet that R.S. had his breathing tube removed at or around 4:00 p.m.

23. On or about January 7, 2006, Respondent documented on R.S.'s critical care flowsheet under pain assessment that R.S. rated his pain from 8:30 a.m. hourly through to 4:30 p.m. as a "6" (moderate pain on the pain scale) and at 5:30 p.m. as a "4" (moderate pain on the pain scale).

24. On January 7, 2006, Respondent documented on R.S.'s critical care flowsheet under pain assessment that R.S. rated his pain at 6:30 as a "2" (mild pain on the pain scale).

RESPONDENT INTERVIEW

25. On or about March 20, 2007, during an interview with Board staff, Respondent stated that he believed he medicated R.S. appropriately, despite documenting pain levels of "6", "4" and "2" and then administering 4 mg IVP MSO4, which did not correspond to the physician order.

////

////

PATIENT M.C. DOCUMENT REVIEW

26. On or about January 24, 2005, Respondent was assigned from 7 a.m. to 7 p.m. to CVICU patient M.C., after he underwent a cardiac catherization, surgical pericardial window and subsequently developed respiratory failure and acute renal failure, medical record number M000301035.

27. On or about January 22, 2005, M.C.'s physician wrote the following order: "MSO4 1-2 mg IVP every 2 hours prn."

28. On or about January 24, 2005, at 11:30 a.m. Respondent obtained a verbal order from Dr. Van Poppel for MSO4 5mg IVP now and another order from Dr. Petre for MSO4 5 mg IVP may repeat times 1."

29. On or about January 24, 2005, Respondent documented on M.C.'s MAR that he medicated M.C. hourly with 4 mg MSO4 IVP from 8:00 a.m. through to 6 p.m., in excess of the physician's order. M.C.'s critical care flowsheet reflected that Respondent documented M.C. was also receiving a continuous sedative infusion, Propofol at 50 mcg/kg/min from 7:00 a.m. to 7:00 p.m.

30. On or about January 24, 2005, Respondent documented on M.C.'s critical care flowsheet revealed that M.C. hourly rated his pain as a "6" (moderate pain on the pain scale) from 8:00 a.m. to 6:00 p.m.

31. On or about January 24, 2005, Respondent documented on M.C.'s MAR that he administered a paralytic agent, Vecuronium 10 mg IVP at 3:30 p.m. and again at 6:30 p.m.

////

////

////

RESPONDENT INTERVIEW

32. On or about March 20, 2007, during an interview with Board staff Respondent stated that M.C. was a very critically ill/unstable patient. Respondent stated that he appropriately administered narcotic analgesics and the Propofol infusion to manage M.C.'s complaints of pain, based upon his observations of M.C.'s agitation and grimacing.

COMPLAINT #2

33. On or about February 23, 2007, a second compliant was filed with the Board from Richard Luna, Senior Vice President, Western Division, Promise Healthcare, Phoenix, AZ. The complaint alleged that Respondent while employed as a registry R.N. and assigned to the 7 p.m. to 7 a.m. shift on November 3, 2006 through to November 4, 2006, inappropriately administered oral pain medications after giving IVP narcotics to patient S.P. and failed to contact S.P.'s physician to clarify/receive further orders; and failed to notify the physician that Respondent was not able to achieve adequate pain control for S.P.; and failed to carry out a specific oxygen therapy physician order for Bi-PAP and failed to maintain S.P. on physician ordered 2 liters/minute of continuous nasal cannula oxygen therapy.

34. Patient S.P.'s medical records revealed his physician transferred him to Promise Healthcare for ongoing physical therapy and rehabilitation. S.P.'s medical history included the following diagnoses: right ankle fracture and status post open reduction and internal fixation (ORIF), chronic renal failure requiring hemodialysis three times a week, chronic anemia, schizophrenia, diabetes mellitus and obstructive sleep apnea requiring Bi-PAP oxygen therapy.

////

DOCUMENT REVIEW

35. A review of S.P.'s medical record revealed the following written admission orders including the following medications and treatments:

> a) Medications: Seroquel 400 mg by mouth every night at bedtime, Ambien 5 mg by mouth every night at bedtime as needed (may repeat times 1; Atarax 50 mg by mouth four times a day as needed;
>
> b) Pain medications: Percocet (5/325) 1 tablet every 4 hours for mild pain; Percocet 2 tablets by mouth for moderate pain and Dilaudid 2 mg IVP every 3 hours as needed for severe pain.
>
> c) Oxygen 2 liters/minute via nasal cannula continuously and Bi-Pap when sleeping at 8 liters/minute.

36. A review of Respondent's documentation from the time of S.P.'s admission on November 3, 2006 until the conclusion of his shift on November 4, 2006 at 7:00 a.m. revealed that Respondent documented the following:

> a) At or about 8:00 p.m. ordered 2/liters of oxygen, nasal cannula was off, S.P.'s oxygenation level was documented as 98%;
> b) At or about 8:20 p.m., Respondent documented S.P.'s pain level as a "9" (pain scale = 9 -10 as the worst imaginable) and administered Dilaudid 2 mg IVP;
> c) At 9:00 p.m., Respondent administered Atarax 50 mg (an antihistamine) and at 9:20 p.m., Respondent documented S.P.'s pain level was a "2";
> d) At or about 10:00 p.m. Respondent documented S.P.'s pain level as "5" and administered Percocet 2 tablets by mouth;
> e) At or about 11:00 p.m., Respondent documented S.P.'s pain level as "2";
> f) At or about 11:15 p.m., Respondent documented S.P.'s pain level as "7" and administered Dilaudid 2 mg IVP;
> g) At or about 12:15 a.m. on November 4, 2006, Respondent documented S.P.'s pain level as "2";
> h) At or about 2:00 a.m. S.P.'s oxygen saturation level was 92% on room air;
> i) At or about 2:15 a.m., Respondent documented S.P.'s pain level as "8" and administered Dilaudid 2 mg IVP;
> j) At or about 2:30 a.m. Respondent administered Ambien 5 mg by mouth (a sleeping agent) to S.P.;

k) At or about 2:35 a.m., Respondent documented S.P.'s pain level as "5" and administered Percocet 2 tablets by mouth;
l) At or about 3:35 a.m., Respondent documented S.P.'s pain level as "2";
m) At or about 5:15 a.m. Respondent documented S.P.'s pain level as "7" and administered Dilaudid 2 mg IVP; and
n) At or about 6:15 a.m. Respondent documented "e.c." (eyes closed).
o) Physician orders for oxygen therapy 8 liters/minute of Bi-Pap was never initiated by Respondent during his entire shift. Respondent failed to notify S.P.'s physician that this intervention was never initiated.

37. On or about November 4, 2005, at approximately 7:40 a.m., S.P. was found by the oncoming shift with an oxygen saturation of 68%, oxygen therapy not connected to S.P. and staff was not able to arouse S.P. At approximately 8:15 a.m., S.P. was noted to be in respiratory distress; arterial blood gases reflected hypoxia.

38. On or about November 4, 2005 at approximately 9:25 a.m., S.P. arrested and emergency ACLS measures were initiated, patient failed to respond to the emergency procedures and died.

RESPONDENT'S INTERVIEW

39. On or about March 20, 2007, during an interview with Board staff, Respondent described his role as the admitting nurse for patient S.P. and was responsible to review and implement all physician orders, assess and treat patient S.P.

40. On or about March 20, 2007, after review of S.P.'s medical record, Respondent acknowledged that he did not document in his narrative nursing notes the patient's reports of pain, required by Promise prn policy and procedure but only documented on the pain assessment/re-assessment pain scale section.

41. According to Respondent, he stated that he did not believe that the medications he administered to S.P. were excessive and the care he rendered inappropriate or inadequate. Respondent stated that the Bi-Pap oxygen treatment was not available, despite being ordered and that he did not notify the physician because that was the responsibility of the charge nurse. Respondent did not comment regarding the failure to assure S.P. had oxygen continuously as ordered.

COMPLAINT #3

42. On or about March 3, 2007, the Board received an anonymous complaint that alleged Respondent was writing prescriptions for controlled substances for friends and receiving half of the filled prescriptions for his own use and as payment for writing the prescriptions.

43. A second anonymous caller contacted the Board and stated that Respondent had been arrested for domestic violence against his wife and family and had threatened police officers and fire department personnel on or about January 27, 2005.

DOCUMENT REVIEW

44. On or about January 27, 2005, the Board received a copy of a Phoenix Police Department report, number 2005-50174556. The report reflected that at or about 11:15 p.m. on January 27, 2005, Respondent was arrested for committing domestic violence by pushing his wife V.G. and kicking her in the head. The police report indicated that Respondent also assaulted his two stepdaughters when they tired to intervene on their mother's behalf.

45. According to the police report, when officers arrived on scene, Respondent was found sitting on the front porch and had a heavy odor of intoxicating liquor, his eyes were noted to be bloodshot and watery. As an officer approached Respondent, he was instructed to remain sitting, he refused. Respondent's lack of cooperation, required officers to take him to the ground and handcuff

him after he continued to resist. Respondent began cursing and making threats to the officers and fire department personnel who were present assisting his family. Respondent told officers, "People will pay, I guarantee it. You did this to me, you will pay. If I ever get your mother in front of me I will torture her like you are torturing me now. I will torture your mother and your sister and your brother and you if I ever get you in my E.R. I will torture everyone in the Glendale P.D.... "Come into my E.R. and I'll fucking give you cyanide, motherfucker." Respondent then started talking to the fire department personnel stating, "God help you if I see you again, if (sic) I see you again I'll kill you."

46. According to the Police Report, Respondent was transported to the hospital because of concerns regarding his diabetes and irrational behavior. After Respondent was released from the hospital and into police custody, he continued to make threats to police officers that he would "get them." Respondent was taken to Maricopa County Jail where he was booked on three counts of Assault/Domestic Violence, a Class 1 misdemeanor.

47. On or about September 9, 2005, a non-jury trial was set after Respondent was charged in Phoenix Municipal Court, criminal case number 3314963 with two counts of intentional assault, one count of threat/intimidation and one count of disorderly conduct.

48. On or about October 19, 2005, the criminal case was dismissed without prejudice, the State was unable to proceed because the victims did not appear in Court.

RESPONDENT'S INTERVIEW

49. On or about March 20, 2007, during an interview with Board staff, Respondent admitted he had been drinking all night on January 27, 2005, when he was arrested by the Phoenix Police Department. Respondent stated it was unusual for him to drink alcohol since it is contraindicated with his diabetes. Respondent stated that he has not used alcohol since this incident.

Respondent stated he did not recall the events leading up to his arrest, and whether he caused the injuries to his wife and step-daughters.

50. A review of Respondent's medical records obtained via subpoena reflected that on or about February 16, 2006, Respondent reported to his cardiologist that he "...drinks wine almost daily."

51. Respondent was asked to describe his current practice as a Family Nurse Practitioner (FNP). Respondent reported that he has a private FNP practice, Sun Valley Health Care, LLC. He described his FNP practice as a mobile practice in which he provides services to individuals in their homes or in other residential settings and that in the past, individuals have been referred to him by physicians (nursing home patients) or by word of mouth.

52. Prior to being informed in the interview of the third complaint, Respondent stated that as a result of the current complaints (1 and 2) he has been "phasing out" his FNP practice under Sun Valley Health Care, and that it is not "operational" at present. Respondent estimated that the last time he saw a patient or wrote a prescription was approximately three weeks prior, and the prescription was for an antibiotic and that he has no current patients scheduled for appointments.

53. After Respondent was informed of complaint #3, he stated that he has written prescriptions for controlled substances for patients as recent as three weeks ago. Respondent denied that he has written prescriptions for controlled substances for others and accepted half of the filled prescription as payment. He denied any history of substance abuse. He reported he currently takes the following prescribed medications, Restoril and Ambien for sleep difficulties associated with working nights and recently receiving a prescription for Xanax related to anxiety secondary to his

licensure complaints. He reported previously being prescribed Soma with Codeine but has not taken any for several months.

54. A review of Respondent's medical records obtained via subpoena reflected that his primary care physician had not documented he had written a prescription for the controlled substance Xanax.

RESPONDENT'S EMPLOYMENT HISTORY

55. A review of Respondent's employment records from Alacrity Staffing and Critical Nursing Solutions revealed that Respondent is a "Do Not Return" in the role of a R.N. at the following facilities: West Valley Hospital, Arrowhead Community Hospital, Phoenix Baptist Hospital, and all the Banner System Hospitals in the Phoenix area.

RESPONDENT'S INTERVIEW

56. On or about March 20, 2007, during an interview with Board staff, Respondent stated that he was not aware of his "DNR" status at these hospitals. Respondent stated however he had since returned to work in the CVICU at PMH in December 2006 and worked through the early part of January 2007.

57. Public health, safety and welfare imperatively requires emergency action.

CONCLUSIONS OF LAW

The Board has the power to issue an Order of Summary Suspension under A.R.S. §§ 41-1092.11(B) and 41-1064(C).

Pursuant to A.R.S. §§ 32-1606, 32-1663, 32-1664, and 41-1064(C) the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. § 32-1663 (F) as defined in A.R.S. § 32-1601 (d) (g) (h) and (j); A.A.C. R4-19-403 – (1) (2) (7) (9) (12) (17) (18) (27) (30) (31); and A.A.C. R4-19-511 (D) (1), (5a), (5b), and (5c).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, the Board hereby summarily suspends the professional nurse license no. RN094171 and advanced practice certificate no. AP0851 of Grant Wayne Cooper.

It is further ordered that a prompt hearing shall be instituted with the Office of Administrative Hearings on this matter.

DATED this 28th day of March, 2007.

SEAL

Joey Ridenour

Joey Ridenour, R.N., M.N.
Executive Director
Arizona State Board of Nursing

COPIES ~~mailed this 28th day of March, 2007, by First Class Mail and Certified Mail Receipt No.~~ Hand-delivered at the Board Office on this 28th day of March, 2007 to:
GRANT WAYNE COOPER
c/o James Lacey
4240 N. 4th Ave.
Phoenix, AZ 85013

COPIES faxed and mailed by First Class Mail this 28th day of March, 2007, to:
and hand-delivered this 28th day of March 2007 to:
Teressa M. Sanzio, P.C., Attorney for Respondent
428 E. Thunderbird Rd., #238
Phoenix, Arizona 85022
Fax: 602-993-7137

COPY hand-delivered this 28th day of March, 2007, to:

Ann Olson
Assistant Attorney General
1275 W. Washington
Phoenix, AZ 85007

COPY faxed this 28th day of March, 2007 to (602) 542-9827 and COPY mailed this 28th day of March, 2007, by First Class Mail to:

Case Management
Office of Administrative Hearings
1700 West Washington, Suite 244
Phoenix, AZ 85007

By: Debra Blake, Paralegal for the Hearing Department

EXHIBIT C

FINDINGS OF FACT, CONCLUSIONS OF LAW AND MODIFIED ORDER NO. 07A-0601022-NUR

STATE OF ARIZONA
This is to certify that this is a true and correct copy of records on file in this office pertaining to Grant Wayne Cooper
ARIZONA STATE BOARD OF NURSING
SEAL
Executive Director

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street Ste 200
Phoenix AZ 85014
602-889-5150

IN THE MATTER OF PROFESSIONAL NURSE LICENSE NO. RN094171 AND ADVANCED PRACTICE CERTIFICATE NO. AP0851 ISSUED TO:
GRANT WAYNE COOPER,

Respondent.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND MODIFIED ORDER NO. 07A-0601022-NUR

A hearing was held before Daniel G. Martin, Administrative Law Judge, at 1400 West Washington Suite 101, Phoenix Arizona, on May 7, May 8, May 11, May 31, June 1 and June 7, 2007. Ann Olson, Assistant Attorney General, appeared on behalf of the State. Grant Wayne Cooper ("Respondent") was present and represented by counsel, Teressa Sanzio.

On July 23, 2007, the Administrative Law Judge issued Findings of Fact, Conclusions of Law and Recommendations. On September 19, 2007, the Arizona State Board of Nursing ("Board") met to consider the Administrative Law Judge's recommendations. Based upon the Administrative Law Judge's recommendations and the administrative record in this matter, the Board adopted the Administrative Law Judge's Findings of Fact and Conclusions of Law and the Board voted to modify the Order for discipline as follows. The Board of Nursing modified the Administrative Law Judge's Order of discipline as they found that the Administrative Law Judge's recommended discipline was insufficient to satisfy the Board's duty to protect the public in the areas of decision-making skills, cognitive reasoning, integrity, differences and boundaries between advanced practice and RN practice. The Board makes the following Findings of Fact and Conclusions of Law.

Respondent filed a Motion for Rehearing in the above-entitled matter on October 19, 2007. The State filed a Response on November 6, 2007. On November 14, 2007, after hearing oral arguments of counsel, reviewing and considering Respondent's Motion and the State's Response, the Board denied

Respondent's Motion for Rehearing, affirmed the Findings of Fact and Conclusions of Law and modified Order No. 07A-0601022-NUR.

FINDINGS OF FACT

1. The Board is the duly constituted authority for licensing and regulating the practice of nursing in the State of Arizona.

2. Respondent is the holder of a professional nurse license (No. RN094171) for the practice of nursing in the State of Arizona. Respondent also holds an advanced practice certificate (No. AP0851) under which he is authorized to independently provide medical services. In his capacity as a nurse practitioner, Respondent was authorized to prescribe and dispense controlled substances.

3. Respondent received his professional nursing license in 1996 and his advanced practice certificate in 1999.

4. Prior to the imposition of the summary suspension that is at issue in this matter, Respondent worked as a registry nurse through Alacrity Staffing ("Alacrity"). Respondent also maintained a private practice, Sun Valley Health Care, LLC, in his capacity as a family nurse practitioner. As a registry nurse, Respondent regularly worked at Phoenix Memorial Hospital ("PMH") in the intensive care unit.

5. On January 25, 2006, the Board received a complaint against Respondent from Marie Gagnon, who at that time was the Director of Professional Practice at PMH. The gravamen of Ms. Gagnon's complaint was that Respondent was over-sedating and over-medicating his patients.

6. The Board assigned responsibility for the investigation of Ms. Gagnon's complaint to Karen Grady, one of the Board's nurse practice consultants.

7. On February 16, 2006, Ms. Gagnon contacted Ms. Grady by telephone to advise that three physicians had raised concerns with her regarding over-medication of patients by Respondent[1]. Ms. Gagnon also told Ms. Grady that one of the respiratory therapists at PMH had complained to her about harassment by Respondent[2].

8. By letter dated February 11, 2006, Ms. Grady advised Respondent that the Board had received a complaint against his nursing license, and provided Respondent with an investigative questionnaire that she asked Respondent to complete and return within two weeks. The questionnaire described the complaint against Respondent as follows: "Alleged unprofessional conduct related to care of patients and medication management while employed at Phoenix Memorial Hospital which has resulted in a do not return status with that facility. Reportedly also a do not return to several other acute care facilities."

9. On March 27, 2006, Respondent through counsel, returned the Board's investigative questionnaire. Given the absence of any specificity in the description of the complaint, Respondent was unable to respond to the allegations[3].

10. On May 17, 2006, Ms. Hartman advised Ms. Grady that two physicians had expressed concern that Respondent might be diverting narcotics. This allegation was not substantiated, and Respondent credibly denied that he had ever diverted narcotics[4].

---

[1] Ms. Gangon had heard from Debra Hartman, who was at that time PMH's Director of Risk Management, that several physicians had complained to Ms. Hartman that it was difficult to wean Mr. Cooper's patients off of their ventilators because they were receiving too much medication. These physicians did not testify at hearing, and the Administrative Law Judge has afforded no weight to these hearsay statements.

[2] This alleged complaint of harassment also constitutes hearsay to which the Administrative Law Judge has afforded no weight.

[3] Respondent requested, and later received, a copy of the complaint that had been submitted to the Board.

[4] There was a further allegation that several members of the PMH ICU staff, including at least one physician, were fearful of Respondent. The totality of the evidence offered in support of this allegation consisted of hearsay to which the Administrative Law Judge has afforded no evidentiary weight.

11. The Board did not have any further contact with Respondent until February 2007, when it received a second complaint against Respondent's nursing license. The gravamen of that complaint was that Respondent had over-medicated a patient while working as a nurse at Promise Specialty Hospital ("PSH") in Phoenix. Of particular note in this instance is that subsequent to the conclusion of Respondent's shift on November 3, 2006, the patient had coded and died.

12. By letter dated March 1, 2007, the Board advised Respondent that a second complaint had been filed against his nursing license.

13. On March 2, 2007, the Board received an anonymous complaint that Respondent had committed an act of domestic violence.

14. On March 3, 2007, the Board received an anonymous complaint that Respondent had written prescriptions for narcotics for,which he had received in return one half of the narcotics dispensed.

15. The Board combined the foregoing complaints into a single complaint for investigative purposes, and assigned responsibility for that investigation to Mary Rappoport, another of the Board's nurse practice consultants.

16. Shortly after commencing its investigation into the foregoing complaints, the Board initiated summary suspension proceedings against Respondent's nursing license and advance practice certificate. As Ms. Rappoport testified at hearing:

> Well, when we got the third complaint in from the D.E.A., the anonymous complaint; we clarified it with the D.E.A. The Board felt it rose to a very high harm, high risk. The summary suspension, you know, was – we thought it was the best thing to do because of the allegations and the fact that we had an issue with another patient from Promise Select Specialty, and then we had allegations of concerns using narcotics, narcotics missing and things along those lines. So the Board had a duty to protect the public, so that's when it rose to a level of a summary suspension.

17. On March 28, 2007, the Board issued Findings of Public Emergency and Order for Summary Suspension, pursuant to which it suspended Respondent's nursing license and advance practice certificate.

18. Subsequent to its entry of the summary suspension order, the Board received two incident reports from Select Specialty Hospital ("SSH"). The gravamen of those reports was that Respondent had over-medicated a patient and that Respondent may have been involved in the loss of ten doses of Dilaudid.

19. On March 28, 2007, following the referral of Respondent's suspension to the Office of Administrative Hearings for formal administrative hearing, the Board issued a Complaint and Notice of Hearing setting this matter for hearing on May 7 and May 8, 2007.

20. In its Complaint, the Board alleged that Respondent had violated A.R.S. § 32-1601(16)(d) (any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public), 32-1601(16)(g) (willfully or repeatedly violating a provision of A.R.S. Title 32, Chapter 15 or a rule adopted pursuant to A.R.S. Title 32, Chapter 15), 32-1601(16)(h) (committing an act that deceives, defrauds or harms the public), and 32-1601(16)(j) (violating a rule that is adopted by the Board pursuant to this chapter). In support of the foregoing, the Board alleged that Respondent had violated Arizona Administrative Code ("A.A.C.") R4-19-403(B)(1) (pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice), (B)(2) (intentionally or negligently causing physical or emotional injury), (B)(7) (failing to maintain a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient), (B)(9) (failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient), (B)(12) (assuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain

nursing competence, or that are outside the scope of practice of the nurse), (B)(17) (pattern of using or being under the influence of alcohol, drugs, or a similar substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location), (B)(18) (obtaining, possessing, administering, or using any narcotic, controlled substance, or illegal drug in violation of any federal or state criminal law, or in violation of the policy of any health care facility, school, institution, or other work location at which the nurse practices), (B)(27) (making a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials), (B)(30) (any act prohibited under R4-19-511(D)), (B)(31) (practicing in any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed), and A.A.C. R4-19-511(D)(1) (prescribing a controlled substance to one's self or a member of the nurse's family), and (D)(5) (prescribing, dispensing, or furnishing a prescription drug or a prescription-only device to a person unless the nurse has examined the person and established a professional relationship, except when the nurse is engaging in one or more of the following: a. providing temporary patient care on behalf of the patient's regular treating and licensed health care professional; b. providing care in an emergency medical situation where immediate medical care or hospitalization is required by a person for the preservation or health, life, or limb; or c. furnishing a prescription drug to prepare a patient for a medical examination). The Administrative Law Judge addresses each of the Board's complaints in turn.

Complaint Number One

21. The Board's first complaint pertains to care that Respondent rendered to three patients at PMH: M.C., R.S., and E.W.

Patient M.C.

22. Patient M.C. was admitted to the PMH cardiovascular intensive care unit ("CVICU") on or about December 22, 2005 after undergoing a cardiac catheterization and surgical pericardial window. The Physician's Orders for M.C., dated December 23, 2005, called for the administration of morphine sulfate 4 mg every hour as needed for pain.

23. Respondent cared for M.C. during the day shift on December 24, 2005 (7:00 a.m. to 7:00 p.m.). Respondent assessed M.C.'s pain every hour, and based on that assessment administered morphine sulfate in accordance with the Physician's Orders. Respondent did not exceed the dosage set forth in the Physician's Orders.

24. In the course of caring for M.C. on December 24, 2005, Respondent administered Propofol, a sedating agent, at an hourly rate of 50 micrograms per kilogram per minute. In administering Propofol to M.C., Respondent did not exceed the maximum amount allowed absent further physician order.

25. In the course of caring for M.C. on December 24, 2005, Respondent administered Vecuronium, a paralytic agent. There is no substantial evidence in the record that Respondent's administration of Vecuronium to M.C. violated a physician order or nursing standard.

26. Respondent's care of M.C. on December 24, 2005 did not cause any harm to M.C.

Patient R.S.

27. Patient R.S. was admitted to the PMH CVICU on or about January 6, 2006 after undergoing a coronary artery bypass. The Physician's Orders for R.S., dated January 6, 2006, called for the administration of morphine sulfate 2 mg every hour as needed for mild pain, 3 mg every hour as needed for moderate pain, and 4 mg every hour as needed for severe pain.

28. Respondent cared for R.S. during the day shift on January 7, 2006. Respondent assessed R.S.'s pain every hour as being in the moderate range, yet administered 4 mg of morphine sulfate, the amount ordered for severe pain, in contravention of the Physician's Orders.

29. Although Respondent acted in contravention of the Physician's Orders when he administered 4 mg of morphine sulfate per hour to R.S., there is no evidence that such medication administration caused any harm to R.S.

Patient E.W.

30. Patient E.W. was admitted to the PMH CVICU on or about January 12, 2006 after undergoing a cardiac catheterization.

31. In accordance with PMH policy, about which Respondent was aware, a change of patient status (such as occurs when a patient is transferred to the CVICU) results in the discontinuance of any then-existing physician orders.

32. In E.W.'s case, his transfer to the CVICU resulted in a discontinuance of his then-existing orders for pain management, which called for the administration of morphine sulfate 4 mg every three hours as needed for pain. Notwithstanding E.W.'s change in status, his pain medication orders continued to appear on his medication administration record ("MAR") through what Robert Garner, PMH's ICU Director, described as a "glitch".

33. Respondent cared for E.W. during the day shifts on January 13, 2006, January 14, 2006, and January 15, 2006. In accordance with the previously-existing physician orders, Respondent administered 4 mg of morphine sulfate to E.W. every three hours to control his pain.

34. The standard of care required that Respondent confirm the MAR for E.W. against physician orders. Respondent violated that standard of care when he relied solely on E.W.'s MAR to confirm that such medication had been ordered.

35. Although Respondent violated the relevant standard of care in his administration of morphine sulfate E.W., there is no evidence that such medication administration caused any harm to E.W.

36. On January 16, 2006, E.W.'s physician entered an order for morphine sulfate 2 mg every four hours as needed for pain.

Additional Evidence re: PMH

37. PMH typically assigned Respondent to care for very ill patients because he had many years of ICU experience, he was competent, he was a good nurse, and physicians trusted him with their patients.

38. When she completed her investigation, Ms. Gagnon concluded that Respondent should be made a "do not return" ("DNR") at PMH. Ms. Gagnon stated at hearing: "my goal was to do a Do Not Return for Mr. Cooper." Ms. Gagnon achieved her goal; PMH DNR'd Respondent on January 20, 2006.

Complaint Number Two

39. The Board's second complaint pertains to care that Respondent rendered to patient S.P. at PSH.

40. On November 3, 2006, S.P. was admitted to PSH as a transfer patient from John C. Lincoln Hospital North Mountain. S.P. had broken his ankle and had undergone an open reduction internal fixation; he was admitted to PSH for physical therapy and pain management.

41. S.P. had numerous medical issues. He was morbidly obese (approximately 460 pounds), suffered from schizophrenia, was diabetic, and required dialysis. S.P. also had obstructive sleep apnea for which he used a bi-pap machine (a medical device that forces respiration).

42. S.P. arrived at PSH at approximately 8:00 p.m. Respondent was working the night shift, having arrived at approximately 7:00 p.m.

43. When S.P. arrived at PSH he was in severe pain, as he had not received any pain medication since 4:40 p.m. The charge nurse, Robert Smith, obtained orders for pain medication as follows: Percocet 5 mg 1 tablet every four hours as needed for mild pain, Percocet 5 mg 2 tablets every four hours as needed for moderate pain and Dilaudid (synthetic morphine) 2 mg every three hours as needed for severe pain. Other medication orders included Seroquel, Ambien, and Atarax, and oxygen (2 liters per minute via nasal cannula continuously and bi-pap when sleeping).

44. When S.P. arrived at PSH, a bi-pap machine had not been obtained. This error appears to be attributable to the day shift having failed to obtain the device, and further to a failure in PSH's medical equipment policies and procedures. The respiratory therapist had documented that S.P. intended to use his own bi-pap machine, but that machine was not brought to the facility.

45. Respondent was aware of the order for the bi-pap, but was unable to implement that therapy in the absence of the bi-pap machine. At hearing, the Board suggested that Respondent could have contacted S.P.'s physician. While this is true, the evidence demonstrated that Respondent in consultation with the charge nurse, Mr. Smith, made an informed judgment that such contact was not required as (i) S.P. slept only intermittently, and (ii) S.P. did not experience any respiratory distress over the course of Respondent's shift (this notwithstanding the fact that S.P. would periodically remove his nasal cannula).

46. At 8:20 p.m. on November 3, 2006, Respondent assessed S.P.'s pain level as severe (9/10), and administered Dilaudid in accordance with the Physician's Orders. On reassessment one hour later, Respondent assessed S.P.'s pain level as moderate (5/10). At 10:00 p.m., Respondent assessed S.P.'s pain level as moderate (5/10), and administered Percocet in accordance with the Physician's Orders. On reassessment one hour later, Respondent assessed S.P.'s pain level as mild (2/10). At 11:25 p.m., Respondent assessed S.P.'s pain level as severe (7/10), and administered

Dilaudid in accordance with the Physician's Orders. On reassessment one hour later, Respondent assessed S.P.'s pain level as mild (2/10). At 2:25 a.m. (now November 4, 2006), Respondent assessed S.P.'s pain level as severe (8/10), and administered Dilaudid in accordance with the Physician's Orders. On reassessment one hour later, Respondent assessed S.P.'s pain level as moderate (5/10). At 2:35 a.m., Respondent assessed S.P.'s pain level as moderate (5/10), and administered Percocet in accordance with the Physician's Orders. On reassessment one hour later, Respondent assessed S.P.'s pain level as mild (2/10). At 2:50 a.m., Respondent administered Ambien in accordance with the Physician's Orders. At 7:00 a.m., Respondent assessed S.P.'s pain level as severe (7/10), and administered Dilaudid in accordance with the Physician's Orders.

47. The State suggested that Respondent's treatment of S.P., as set forth above, violated a PSH policy and procedure that when a patient experiences pain at a rate consistently 5 or greater, and such pain is unrelieved by medication and nonpharmacologic interventions, the situation should be reported to the patient's physician. The Administrative Law Judge disagrees that a violation of this policy occurred, as the evidence demonstrated that S.P.'s pain *was* relieved by medication.

48. The State urged that Respondent's administration of Dilaudid, Percocet, and Ambien within a 35 minute time frame (*i.e.*, between 2:25 a.m. and 2:50 p.m.) did not represent the conduct of a prudent nurse. The weight of the evidence was contrary to this assertion. Respondent treated S.P.'s pain according to (and under the limitations imposed by) the Physician's Orders, and at no point during his shift did Respondent exceed those orders.

49. At the conclusion of his shift, Respondent noted in the medical record that S.P.'s vital signs were stable and that the evening's care had been uneventful. The evidence supports this notation. Recognizing that reasonable persons can interpret the term "uneventful" differently, it remains that at

no time during the course of Respondent's shift were there any incidents of sufficient moment or magnitude as to require physician contact or extraordinary intervention.

50. At approximately 8:15 a.m. on November 4, 2006, S.P. began to experience respiratory distress. At 9:25 a.m., S.P. coded and could not be resuscitated.

51. Following the occurrence of this "sentinel event" (the death of a patient within 24 hours after admission), PSH initiated a root cause analysis. That analysis identified S.P.'s medication regimen, as administered by Respondent, as a potentially contributing factor, but nothing in any of the documentation admitted into evidence states that Respondent acted inappropriately or in violation of the Nurse Practice Act.

52. Following S.P.'s death, Respondent was DNR'd at PSH. That prohibition was lifted in January 2007, and Respondent returned to PSH as a charge nurse.

Complaint Number Three

53. Paragraph 42 of the Board's Complaint and Notice of Hearing alleges: "On or about March 3, 2007, the Board received an anonymous complaint that alleged [Respondent] was writing prescriptions for controlled substances for friends and relatives and receiving half of the filled prescriptions for his own use and as payment for writing the prescriptions."

54. The State did not present any substantial evidence at hearing to support this allegation, and Respondent credibly denied any wrongdoing.

55. In a section of the Complaint and Notice of Hearing entitled "Document Review", the Board states that Respondent had written prescriptions for controlled substances to family, friends, and co-workers, and that Respondent had received prescriptions for controlled substances.

56. Respondent acknowledged that he wrote two prescriptions for Valium for his wife. Respondent explained that extenuating circumstances existed; however, such circumstances do not excuse Respondent's conduct.

57. The State demonstrated, through pharmacy records, that Respondent had written prescriptions to co-workers and others; however, the State failed to demonstrate that such prescriptions were improper[5]. At one point during the hearing, Julie Saltzman, one of the Board's witnesses, testified that she had received a prescription from Respondent as follows:

> Q. And you stated that you thought he [Mr. Cooper] was a good nurse. Now everyone's interpretation of what good may be different. Did that include that you thought he had advanced knowledge because he held an advanced practice certificate?
> A. For many years I did not know Grant was a nurse practitioner if that's what you are asking. I knew Grant continued to go to school and had gone to seminars and whatnot to keep himself current on current practice of critical care patients.
> Q. So when did you find out that he held an advanced practice certificate?
> A. I honestly don't know when I knew that.
> Q. How did you find out? Did he tell you directly?
> A. No. One day I was at the hospital and I wasn't feeling well and he asked me what was wrong and he asked me, I'm a nurse practitioner. I can write a prescription for antibiotics if you need me to.
> Q. Did he do so?
> A. One time for Zithromax.
> Q. Did he do a complete intake of you and create a medical record for you as a patient of his?
> A. Yes. We went in the conference room so it could be private or confidential, I'm sorry.

58. Ms. Saltzman's testimony, which the Administrative Law Judge found very credible, supports Respondent's assertion that he did not write prescriptions without first performing a medical work-up.

59. Regarding Respondent's receipt of controlled substances, the evidence demonstrated that such prescriptions were written by physicians or physician assistants in response to various medical

---

[5] At hearing, the State urged that Respondent had failed to produce patient records in response to subpoena, and thus had prevented the Board from fully investigating the allegations of improper prescribing. As the evidence demonstrated, Respondent made a good faith attempt to comply with the Board's subpoena, but, due to pending divorce proceedings and the issuance of a temporary restraining order against him, was unable to retrieve the records from his home, which is currently occupied by his wife. The Administrative Law Judge finds no cause to delve further here into the nature of Respondent's marital difficulties. Suffice to say, Respondent has been placed in an extremely difficult and tenuous position, and his inability to produce records to the Board in its investigation is not a matter that should be held against him.

conditions. There is no substantial evidence in the record that Respondent obtained such prescriptions for improper purposes[6].

60. Paragraph 43 of the Board's Complaint and Notice of Hearing alleges: "A second anonymous caller contacted the Board and stated that Respondent had been arrested for domestic violence against his wife and family and had threatened police officers and fire department personnel on or about January 27, 2005."

61. Respondent did not dispute that he had been arrested. That arrest, however, did not give rise to a conviction, and the arrest, in and of itself, is neither substantial nor probative evidence of the commission of the offense relied upon by the Board.

62. At hearing, the State offered into evidence several police reports, one of which addressed Respondent's arrest. The Administrative Law Judge rendered a preliminary ruling that the reports were not admissible unless they could be shown to be corroborative of other, more direct evidence of Respondent's conduct. The State did not offer any such evidence (including not questioning Respondent directly), and the reports were not admitted into evidence.

63. In the absence of any substantial or probative evidence as to Respondent's alleged conduct on January 27, 2005, the State failed to demonstrate that Respondent engaged in any improper or wrongful conduct as alleged in Complaint and Notice of Hearing.

Complaint Number Four

64. The Board's fourth complaint pertains to care that Respondent rendered to patient B.D. at Select Specialty Hospital ("SSH") in Phoenix, and to the discovery of missing medication at an SSH location at which Respondent was working.

---

[6] The closest issue in regard to Respondent's personal use of medication was his receipt in March 2007 of a prescription for 240 doses of Desoxyn, a form of methamphetamine used to treat Attention Deficit Disorder. The quantity is significant; however, the Administrative Law Judge finds, upon consideration of the testimony of Dr. Celaya, the prescribing physician, that the amount prescribed (which represents a one month supply) was not inordinate.

Patient B.D.

65. Patient B.D. was admitted to SSH on or about January 2, 2007 for rehabilitation following a motor vehicle accident in which he sustained significant injuries. Dr. Lindley Bliss was B.D.'s admitting physician.

66. Dr. Bliss' orders called for the administration of Dilaudid 1 mg every hour as needed for pain.

67. Respondent cared for B.D. during the evening shift on January 13, 2007. Respondent assessed B.D.'s pain as moderate (5/10) at 8:00 p.m., 9:00 p.m., 10:30 p.m., and 4:00 a.m., and based on that assessment administered Dilaudid in accordance with Dr. Bliss' orders. Respondent did not exceed Dr. Bliss' orders.

68. Respondent's care of B.D. on January 2, 2007 did not cause any harm to B.D.

Missing Dilaudid

69. On February 18, 2007, Thomas Bromert, the Director of Pharmacy Services at SSH, received a report that 10 doses of Dilaudid had been discovered missing from one of SSH's Pyxis medication dispensing stations. According to Mr. Bromert, a pharmacist had stocked the station on February 16, 2007 with 2 boxes of Dilaudid, each containing 10 carpujects. On February 18, 2007, a nurse who had accessed the station had discovered that the carpujects had been removed from one of the boxes and replaced with plastic sleeves to give the appearance that the box was full.

70. Mr. Bromert ran a report and determined that Respondent was one of two nurses who had accessed the Dilaudid supply between the re-stocking on February 16, 2007 and the discovery on February 18, 2007 of the missing carpujects (the second nurse being the one who had discovered the missing medication).

71. SSH drug tested all of its employees who had access to the dispensing station and/or the pharmacy. All of those tests were negative.

72. SSH could not require that Respondent submit to a drug test, as he was not an SSH employee. However, SSH submitted a request to Alacrity that Respondent take a drug test, which request was passed on to Respondent.

73. On February 20, 2007, Respondent underwent a drug test; that test was negative.

74. Other than the testimony by Mr. Bromert, the State did not present any evidence that Respondent had removed the Dilaudid carpujects from the dispensing station. While Mr. Bromert was a credible witness, the fact that Respondent had accessed the dispensing station, standing alone, is not sufficient evidence to establish that Respondent took the medication.

Other Issues/Other Matters

75. During the course of the hearing, which lasted six days (plus one additional day for closing argument), the parties addressed multiple matters and issues. To the extent that the Administrative Law Judge has not addressed such matters and/or issues specifically herein, it because they were excluded from the record or because the Administrative Law Judge determined such matters to be irrelevant to the violations alleged in the Complaint and Notice of Hearing or unsupported by the evidence[7].

CONCLUSIONS OF LAW

1. In this proceeding, the Board bears the burden to prove, by a preponderance of the evidence, that Respondent engaged in unprofessional conduct as defined in A.R.S. § 32-1601(16)(d), (g), (h), and/or (j), and that he is subject to disciplinary action pursuant to A.R.S. §§ 32-1663 and 32-1664. *See* A.A.C. R2-19-119.

[7] One example would be the reference in Complaint and Notice of Hearing ¶ 59 to Respondent having left a briefcase containing $18,000.00 with Mr. Bromert at the SSH pharmacy. Respondent offered a reasonable explanation for that occurrence, which the Administrative Law Judge could have addressed in detail, but ultimately that set of facts simply is not relevant to Respondent's alleged violation of the Nurse Practice Act. Another example is the issue of the legibility of Respondent's handwriting. The evidence on this issue was mixed, but, ultimately, it is not an issue that requires further analysis because the legibility of Respondent's handwriting was not alleged in the Board's Complaint and Notice of Hearing as a violation of the Nurse Practice Act.

2. A preponderance of the evidence is "such proof as convinces the trier of fact that the contention is more probably true than not." Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

3. The Administrative Law Judge concludes, based on the evidence presented, that the Board sustained its burden of proof as to two of Respondent's alleged violations of the Nurse Practice Act.

4. A.R.S. § 32-1601(16) provides, in pertinent part:

> "Unprofessional conduct" includes the following whether occurring in this state or elsewhere:
>
> (d) Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.
>
> (g) Willfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter.
>
> (h) Committing an act that deceives, defrauds or harms the public.
>
> (j) Violating a rule that is adopted by the Board pursuant to this chapter.

5. A.A.C. R4-19-403(B) provides, in pertinent part:

> For purposes of A.R.S. § 32-1601(16)(d), any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public includes one or more of the following:
>
> 1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;
>
> 2. Intentionally or negligently causing physical or emotional injury;
>
> 7. Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient;
>
> 9. Failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient;
>
> 12. Assuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse;

17. A pattern of using or being under the influence of alcohol, drugs, or a similar substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location;

18. Obtaining, possessing, administering, or using any narcotic, controlled substance, or illegal drug in violation of any federal or state criminal law, or in violation of the policy of any health care facility, school, institution, or other work location at which the nurse practices;

27. Making a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials;

30. For a registered nurse granted prescribing privileges, any act prohibited under R4-19-511(D); or

31. Practicing in any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed.

6. A.A.C. R4-19-511(D) provides, in pertinent part:

In addition to acts listed under R4-19-403, for a nurse who prescribes or dispenses a drug or device, a practice that is or might be harmful to the health of a patient or the public, includes one or more of the following:

1. Prescribing a controlled substance to one's self or a member of the nurse's family;

5. Prescribing, dispensing, or furnishing a prescription drug or a prescription-only device to a person unless the nurse has examined the person and established a professional relationship, except when the nurse is engaging in one or more of the following:

a. Providing temporary patient care on behalf of the patient's regular treating and licensed health care professional;

b. Providing care in an emergency medical situation where immediate medical care or hospitalization is required by a person for the preservation or health, life, or limb; or

c. Furnishing a prescription drug to prepare a patient for a medical examination.

7. The evidence demonstrated that Respondent administered excessive medication to patient R.S. at PMH on January 7, 2006. Such conduct constitutes a violation of A.R.S. § 32-

1601(16)(d), as the administration of excessive medication, while it did not cause any harm to R.S., is a practice that might be harmful or dangerous to the health of a patient.

8. The evidence demonstrated that Respondent failed to confirm the physician's orders for medication for patient E.W. at PMH on January 13, 14, and 16, 2006, and thus administered medication to E.W. over the course of three days without a valid order. Such conduct constitutes a violation of A.R.S. § 32-1601(16)(d), as the administration of medication without a valid order, while it did not cause any harm to E.W., is a practice that might be harmful or dangerous to the health of a patient. Such conduct also violates A.A.C. R4-19-403(B)(9), and in turn A.R.S. § 32-1601(16)(j), as the administration of medication without a valid physician order constitutes a failure to take appropriate action to safeguard a patient's welfare.

9. The evidence demonstrated that Respondent prescribed Valium to his wife. Such conduct constitutes a violation of A.A.C. R4-19-511(D)(1), and in turn A.R.S. § 32-1601(16)(j), as the issuance of a prescription to a family member is expressly prohibited.

10. As to the remainder of the Board's allegations, the evidence failed to demonstrate that Respondent willfully or repeatedly violated a provision of A.R.S. Title 32, Chapter 15 or a rule adopted pursuant to A.R.S. Title 32, Chapter 15 (A.R.S. § 32-1601(16)(g)), committed an act that deceived, defrauded or harmed the public (32-1601(16)(h)), exhibited a pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice (A.A.C. R4-19-403(B)(1)), intentionally or negligently caused physical or emotional injury (A.A.C. R4-19-403(B)(2)), failed to maintain a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient (A.A.C. R4-19-403(B)(7)), assumed patient care responsibilities that the nurse lacked the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse (A.A.C. R4-19-403(B)(12)), exhibited a pattern of using

or being under the influence of alcohol, drugs, or a similar substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location (A.A.C. R4-19-403(B)(17)), obtained, possessed, administered, or used any narcotic, controlled substance, or illegal drug in violation of any federal or state criminal law, or in violation of the policy of any health care facility, school, institution, or other work location at which the nurse practices (A.A.C. R4-19-403(B)(18)), or made a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials (A.A.C. R4-19-403(B)(27)).

11. A.R.S. § 32-1663 provides, in pertinent part:

> D. If the Board finds after affording an opportunity to request an administrative hearing that a person who holds an Arizona nursing license has committed an act of unprofessional conduct it may do any of the following:
>
> 1. Revoke or suspend the license.
> 2. Impose a civil penalty.
> 3. Censure the licensee.
> 4. Place the licensee on probation.
> 5. Accept the voluntary surrender of a license.
>
> F. If the Board finds after affording an opportunity to request an administrative hearing that a certificate holder has committed an act of unprofessional conduct it may do any of the following:
>
> 1. Revoke or suspend the certificate.
> 2. Impose a civil penalty.
> 3. Accept the voluntary surrender of a certificate.

12. A.R.S. § 32-1664 provides, in pertinent part:

> N. If the licensee or certificate holder is found to have committed an act of unprofessional conduct, the Board may revoke or suspend the license or the certificate.

13. Having considered the foregoing authorities and the violations found herein, the Administrative Law Judge concludes that grounds exist to impose discipline against Respondent's

license. However, grounds do not exist to support the Board's imposition of summary suspension, and that Order must be reversed.

ORDER

In view of the Findings of Fact and Conclusions of Law, the Board issues the following Order:

Pursuant to A.R.S. § 32-1664(N), the Board lifts the summary suspension of professional nurse license number RN094171 issued to Grant Wayne Cooper and places professional nurse license RN094171 on probation for 18 months with terms and conditions. The Board also suspends advanced practice certificate number AP0851 issued to Grant Wayne Cooper for 6 months with terms and conditions.

A. Respondent's professional nurse license is placed on probation for 18 months and Respondent's AP certificate is suspended for 6 months beginning the effective date of this Order. Prior to termination of probation, Respondent shall work as a professional nurse for a minimum of 18 months with 12 of those months being as an advanced practice nurse (not less than sixteen hours a week).

B. If Respondent is noncompliant with any of the terms of the Order, Respondent's noncompliance shall be reviewed by the Board for consideration of possible further discipline on Respondent's nursing license.

C. If Respondent is convicted of a felony, Respondent's license shall be automatically revoked for a period of five years. Respondent waives any and all rights to a hearing, rehearing or judicial review of any revocation imposed pursuant to this paragraph.

D. Probation is subject to the following terms and conditions:

TERMS OF PROBATION

1. Stamping of License

Within seven days of the effective date of this Order, Respondent shall submit his license to be stamped **"PROBATION."** While this Order is in effect, if the Board issues any certificates or licenses authorized by statute, except a nursing assistant certificate, such certificate or license shall also be stamped "probation." Respondent is not eligible for a multistate "Compact" license.

2. Role Theory for Advanced Practice Nurses

Prior to completion of the 18-month probation, Respondent shall submit to the Board or its designee for prior approval, a course outline/objectives or course syllabus for a graduate level course in role theory for the advanced practice nurse. This requirement can be satisfied by an on-line graduate level course that is credit-based. Respondent shall then provide written proof from the instructor or provider of the course, verifying enrollment, attendance, and successful completion of each required course or program. Following the successful completion of each course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order based on the recommendation(s) of the course instructor.

3. Ethical Aspects of Nursing

Prior to completion of the 18-month probation, Respondent shall submit to the Board or its designee for prior approval, a course outline/objectives or course syllabus for a graduate level course in Ethical Aspects of Nursing for the advanced practice nurse. This requirement can be satisfied by an on-line graduate level course that is credit-based. This requirement can also be satisfied by taking the graduate level course in Role Theory that includes an Ethics component for the advanced practice

nurse. Respondent shall then provide written proof from the instructor or provider of the course, verifying enrollment, attendance, and successful completion of each required course or program. Following the successful completion of each course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order based on the recommendation(s) of the course instructor.

4. Pharmacology Course

Prior to completion of the 18-month probation, Respondent shall submit to the Board or its designee for prior approval, a course outline/objectives or syllabus for a graduate level course or program in Pharmacology. This requirement can be satisfied by an on-line graduate level course that is credit-based. Respondent shall then provide written proof from the instructor or provider of the course verifying enrollment, attendance, and successful completion of the required course or program. Following the successful completion of the course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order based on the recommendation(s) of the course instructor.

5. Notification of Practice Settings

Any future setting in which Respondent accepts employment which requires RN licensure, shall be provided with a copy of the entire Order on or before the date of hire. Within seventy-two hours of the effective date of the Order or within 7 days of Respondent's date of hire, if it occurs after the effective date of the Order, Respondent shall cause his immediate supervisor to inform the Board, in writing and on employer letterhead, acknowledging the supervisor's receipt of a copy of this Order and the employer's ability to comply with the conditions of probation.

After 6 months, and upon reactivation of the Advanced Practice Certificate, any setting in which Respondent accepts employment, which requires Advanced Practice Certification shall be

provided with a copy of the entire Order on or before the date of hire. Within seventy-two hours of the effective date of the Order or within 7 days of Respondent's date of hire, if it occurs after the effective date of the Order, Respondent shall cause his immediate supervisor to inform the Board, in writing and on employer letterhead, acknowledging the supervisor's receipt of a copy of this Order and the employer's ability to comply with the conditions of probation.

6. Quarterly Reports

Within 7 days of each assigned quarterly reporting due date, if Respondent is working in any position which requires RN licensure or Advanced Practice certification, Respondent shall cause **every** employer Respondent has worked for during the quarter to provide to the Board, in writing, employer evaluations on the Board-approved form. The first report is due on the first assigned quarterly report due date after the effective date of the Order. Receipt of notice of an unsatisfactory employer evaluation, verbal or written warning, counseling or disciplinary action any of which pertain to patient care practice issues, or termination from a place of employment shall be considered as noncompliance with the terms of the Order.

In the event Respondent is not working in a position which requires RN licensure and/or Advanced Practice Certification, Respondent shall provide to the Board, in writing, a self-report describing other employment or activities on the Board-approved form. Failure to provide employer evaluations/or self-reports within 7 days of the reporting date shall be considered as noncompliance with the terms of the Order.

7. Practice Under **Direct** Supervision

For the first twelve (12) months of this Order, including the first six (6) months of return to advanced practice nursing following completion of suspension of his AP certificate, Respondent shall practice as an advanced practice nurse and/or professional nurse, only under the direct supervision

of an advanced practice nurse and/or professional nurse in good standing with the Board. **Direct supervision is defined as having an advanced practice nurse and/or professional nurse present on the same unit with Respondent whenever Respondent is practicing as a professional nurse**. During the last 6 months of probation, Respondent shall practice as a professional nurse, only under the on-site supervision of a professional nurse in good standing with the Board. **On-site supervision is defined as having an advanced practice nurse and/or professional nurse in present in the building while Respondent is on duty**.

The supervising nurse shall have read this Order to include the Findings of Fact, Conclusions of Law and Order, and shall provide input on Respondent's employer evaluations to the Board. The supervising nurse shall be primarily one person, who may periodically delegate to other qualified personnel, who shall also have read this Order in its entirety. In the event that the assigned supervising nurse is no longer responsible for the supervision required by this paragraph, Respondent shall cause his new supervising nurse to inform the Board, in writing and on employer letterhead, acknowledgment of the new supervisor's receipt of a copy of this Order in its entirety, and the new supervising nurse's agreement to comply with the conditions of probation within ten days of assignment of a new supervisor.

8. Practice Under On-Site Supervision (applied to RN license only)

Respondent shall practice as a professional nurse only under the on-site supervision of a professional nurse in good standing with the Board for months 13 through 18 of probation. **On-site supervision is defined as a professional nurse in present in the building while Respondent is on duty.** The supervising nurse shall have read this entire Order and shall provide input on Respondent's employer evaluations to the Board. The supervising nurse shall be primarily one person, who may periodically delegate to other qualified personnel, who shall also have read this entire Order.

In the event that the assigned supervising nurse is no longer responsible for the supervision required by this paragraph, Respondent shall cause her new supervising nurse to inform the Board, in writing and on employer letterhead, acknowledgment of the new supervisor's receipt of a copy of this Order and the new supervising nurse's agreement to comply with the conditions of probation within seven days of assignment of a new supervising nurse.

9. Acceptable Hours of Work

Respondent can work any shift. Within a 14-day period Respondent shall not work more than 84 scheduled hours.

Respondent may work three 12-hour shifts in one seven day period and four 12-hour shifts in the other seven-day period, but Respondent may not work more than 3 consecutive 12-hour shifts during this probationary period. Respondent shall not work 2 consecutive 8 hour shifts within a 24 hour period or be scheduled to work 16 hours within a 24 hour period.

10. Registry Work Prohibited

Respondent may not work for a nurse's registry, home health, traveling nurse agency, any other temporary employing agencies, float pool, or position that requires on-call status.

11. Out-of-State Practice/Residence

Before any out-of-state practice or residence can be credited toward fulfillment of these terms and conditions, it must first be approved by the Board prior to leaving the state. If Respondent fails to receive such approval before leaving the state, none of the time spent out-of-state will be credited to the fulfillment of the terms and conditions of this Order.

12. Release of Information Forms

Respondent shall sign all release of information forms as required by the Board or its designee and return them to the Board within 10 days of the Board's written request. If Respondent

failed to execute the releases, his license shall be reviewed by the Board for consideration of possible further discipline on his license.

13. Interview With the Board or Its Designee

Respondent shall appear in person or if residing out of state telephonically for interviews with the Board or its designee upon request at various intervals and with reasonable notice.

14. Renewal of License

In the event the Respondent's professional nurse license is scheduled to expire while this Order is in effect, Respondent shall apply for renewal of the license, pay the applicable fee, and otherwise maintain qualification to practice nursing in Arizona.

15. Change of Employment/Personal Address/Telephone Number

Respondent shall notify the Board, in writing, within one week of any change in nursing employment, personal address or telephone number.

16. Obey All Laws

Respondent shall obey all federal, state and local laws, and all laws/rules governing the practice of nursing in this state. Offenses such as driving under the influence may subject Respondent to further disciplinary action, however, commission of minor civil traffic moving violations are excluded.

17. Costs

Respondent shall bear all costs of complying with this Order.

18. Violation of Probation

If Respondent is noncompliant with this Order in any respect, the Board or its designee may notify Respondent's employer of the noncompliance. Additionally, the Board may revoke suspension of Respondent's AP certificate and/or probation of his AP certificate or RN license and take

further disciplinary action for noncompliance with this Order after affording Respondent notice and the opportunity to be heard. If a complaint or petition to revoke probation is filed against Respondent during suspension and/or probation of his AP certificate or RN license, the Board shall have continuing jurisdiction until the matter is final, and the period of suspension and/or probation shall be extended until the matter is final.

19. Voluntary Surrender of License

Respondent may, at any time this Order is in effect, voluntarily request surrender of his professional nursing license which would include the advanced practice certificate.

20. Completion of Probation

Upon successful completion of the terms of probation for both the AP certificate and RN license, Respondent shall request formal review by the Board and, after formal review by the Board, Respondent's nursing license and advanced practice certificate may be fully restored by the appropriate Board action if compliance with this Order has been demonstrated to the Board's satisfaction.

This Order constitutes a final administrative decision of the Board which is reviewable by the Superior Court pursuant to A.R.S. §§ 12-901 through 12-914. This decision is binding on Respondent from the date of the Board's Modified Order as mandated in A.A.C. R4-19-609 unless and until Respondent secures a Stay Order from Superior Court.

DATED this 19th day of September, 2007.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour, R.N., M.N.
Executive Director

COPIES mailed this 21st day of September, 2007, by Certified Mail No. 7001 1940 0003 4512 5554 and First Class Mail to:

Grant Wayne Cooper
6336 W Honeysuckle Dr
Phoenix AZ 85083

COPIES mailed this 21st day of September, 2007, by Certified Mail No. 7001 1940 0003 4512 5561 and First Class Mail to:

Teressa M. Sanzio
Attorney at Law
428 E Thunderbird Rd #238
Phoenix AZ 85022

COPIES of the foregoing mailed this 21st day of September, 2007, to:

Case Management
Office of Administrative Hearings
1400 W Washington Ste 101
Phoenix AZ 85007

COPIES mailed this 23rd day of November, 2007. by Certified Mail No. 7001 1940 0003 4512 6469 and First Class Mail to:

Grant Wayne Cooper
6336 W Honeysuckle Dr
Phoenix AZ 85083

COPIES mailed this 23rd day of November, 2007 by Certified Mail No. 7001 1940 0003 4512 6476 and First Class Mail to:

Teressa Sanzio
Attorney at Law
428 E Thunderbird Rd Ste 238
Phoenix AZ 85022

COPY mailed this 23rd day of November, 2007, to:

Kim E. Zack
Assistant Attorney General
1275 W. Washington
Phoenix, AZ 85007

By: Vicky Driver